

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/02/2012	
NAME OF PROVIDER OR SUPPLIER MARQUETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260			
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F0000	<p>This visit was for the Investigation of Complaint IN00111505.</p> <p>Complaint IN00111505- Substantiated. Federal/state deficiencies related to the allegations are cited at F-282, F-333, F-425 and F-514.</p> <p>Survey Dates: July 31 and August 1 & 2, 2012</p> <p>Facility Number: 000105 Provider Number: 155198 AIM Number: N/A</p> <p>Survey Team Diana Zgonc, RN- TC Connie Landman, RN</p> <p>Census Bed Type: SNF: 85 Residential: 57 Total: 142</p> <p>Census Payor Type: Medicare: 33 Private: 109 Total: 142</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings</p>			F0000	<p>The creation and submission of this plan of correction does not constitute an admission of any conclusion set forth in the statement of deficiencies or any violation of regulations.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	cited in accordance with 410 IAC 16.2. Quality review completed on August 3, 2012 by Bev Faulkner, RN						

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident received prescribed medications as ordered by the physician for 1 of 3 residents reviewed for medication orders (Resident 'B').</p> <p>Findings include:</p> <p>The record for Resident 'B' was reviewed on 7/31/12 at 12:15 P.M.</p> <p>Diagnoses for Resident 'B' included but were not limited to chronic obstructive pulmonary disease, asthma, shortness of breath, depression, coronary artery disease, osteopenia, gastroesophageal reflux disease and hypothyroidism.</p> <p>Resident 'B' was admitted to the facility on 5/15/12 at 18:38:42 (6:38 P.M.).</p> <p>The physician's orders on admission included, but were not limited to the following medications: albuterol-ipratropium nebulizer inhalation every 4 hours, next dose due at 8:30 p.m. fluticasone-salmeterol (advair) 500-50 inhalation, twice a day, next dose due at</p>			F0282	<p>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - No corrective action can be made at this time for Resident B, because this resident was discharged prior to the commencement of this survey. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>- All newly admitted residents have the potential to be affected by the alleged deficient practice.</p> <p>- The contracted pharmacy has confirmed their ability to provide medications 24 hours every day, and has a contract with another nationwide pharmacy to provide backup medications as needed. The contracted pharmacy will deliver medications within four hours of receipt of physician's orders.</p> <p>- If unpreventable events hinder deliver of medications administration per physicians' orders, the Emergency Drug Kit (EDK) will be utilized in accordance to regulation. Otherwise, the physician will be contacted to request an order to</p>		09/01/2012

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	<p>9:00 p.m. montelukast (Singulair 10 milligrams [mg]) orally every evening, next dose due at 9:00 p.m. rosuvastatin (Crestor 5 mg orally) once a day, next dose due at 9:00 p.m. trazadone (150 mg orally) at bed time, next dose due at 9:00 p.m. verapamil (40 mg orally) twice a day, next dose due at 9:00 p.m.</p> <p>The medication administration record on discharge from the hospital on 5/15/12 indicated the resident did receive her morning medications prior to discharge but did not receive any evening medications. The medication administration record (MAR) for May indicated the resident did not receive the evening ordered medications on 5/15/12.</p> <p>During an interview with the 1st floor Unit Manager on 7/31/12 at 10:45 A.M., she indicated "We have a lot of evening admissions. We have to get the orders verified from the physician and then we fax the meds to the pharmacy for a STAT delivery, they have 4 hours to get the meds here...."</p> <p>During an interview with LPN #1 on 7/31/12 at 3:00 P.M., she indicated "There were problems with the pharmacy,</p>				<p>hold, to delay, or to use an alternative course of treatment. - What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - All licensed nurses will be re-educated as to the policy and procedure for obtaining medications or alternate direction as prescribed by the physician, as outlined above. - As part of job-specific orientation, newly hired nurses will be educated as to the policy and procedure for obtaining medications or alternate direction as prescribed by the physician, as outlined above. - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: - For two months, nursing management will audit each new admission for the timely delivery of medications, administration of medications per physician's orders, and utilization of the EDK. - Information gathered from the audits will be forwarded to the Quality Assurance Committee to determine a future auditing schedule.</p>		

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	<p>they didn't have a medication and needed clarification of the physician's orders. It was late, there was a lot of havoc going on and the physician had not called us back. We had to make several phone calls and the administrator finally had to call the physician directly. The resident was very upset about her medications."</p> <p>3.1-35(g)(2)</p>						

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F0333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on record review and interview, the facility failed to ensure a resident received the ordered medication, Singulair, during the first 4 days after admission for 1 of 3 residents reviewed for medication orders (Resident 'B'). This caused the resident additional stress and distrust of the nursing staff.</p> <p>Findings include:</p> <p>The record for Resident 'B' was reviewed on 7/31/12 at 12:15 P.M.</p> <p>Diagnosis for Resident 'B' included but were not limited to chronic obstructive pulmonary disease, asthma, shortness of breath, depression, coronary artery disease, osteopenia, gastroesophageal reflux disease and hypothyroidism.</p> <p>Resident 'B' was admitted to the facility on 5/15/12 at 18:38:42 (6:38 P.M.).</p> <p>The hospital discharge instructions, dated 5/15/12, indicated Resident 'B' had a need for montelukast (Singulair) 10 milligrams (mg) taken orally every evening.</p> <p>Review of the physician's orders provided</p>		F0333	<p>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - No corrective action can be made at this time for Resident B, because this resident was discharged prior to the commencement of this survey. - Nurses involved in the medication errors detailed in this alleged deficiency have been educated or disciplined per policy. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - All newly admitted residents have the potential to be affected by the alleged deficient practice. - All new admission orders will transcribed by a licensed nurse. A second licensed nurse will check completed entries for accuracy of transcription. Both nurses will sign the admission medication administration record.</p> <p>- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - All licensed nurses will be re-educated as to the process of checking admission orders,</p>		09/01/2012	

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	<p>to the pharmacy and verified by LPN #1 indicated the Singulair was not included in the list of requested medications.</p> <p>Review of the Medication Administration Record (MAR) for May indicated the resident did not receive the Singulair on 5/15, 5/16, 5/17 or 5/18/12.</p> <p>A telephone order, dated 5/18/12, indicated the Singulair was not requested with the original admission medications.</p> <p>A social service note, dated 5/17/12 at 12:38 P.M., indicated "... the resident was very out spoken about medication incidents of the first night here..."</p> <p>A nursing note, dated 5/18/12 at 9:13 P.M., indicated the resident complained she was not getting her Singulair. Nursing verified the Singulair had been omitted on the admission orders to the pharmacy.</p> <p>A social service note, dated 5/22/12 at 2:40 P.M., indicated "... the resident was very angry that she had not been given her medications at the appropriate times and she was keeping a log of meds dispensed."</p> <p>A social service note, dated 5/22/12 at 2:42 P.M., indicated "... the resident feels</p>			<p>including signing to confirm transcription accuracy on the admission medication administration record as outlined above. - As part of job-specific orientation, newly hired nurses will be educated as to process of checking admission orders, including signing to confirm transcription accuracy on the admission medication administration record as outlined above. - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: - For two months, nursing management will audit each new admission for the completion of the double checking of admission orders. Information gathered from the audits will be forwarded to the Quality Assurance Committee to determine a future auditing schedule.</p>			

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	<p>additional stress due to worry about her medication and having to keep a log. Resident was assured she did not have to continue to log medications but indicated the resident would because of distrust."</p> <p>An activity note, dated 5/22/12 at 3:03 P.M., indicated the resident was somewhat agitated "... not happy about her medications."</p> <p>During an interview with the Director of Nursing on 8/1/12 at 10:45 A.M., she indicated they were tracking medication errors on the "Medication Dispensing Events" form (form provided) and Resident 'B' had not been receiving her Singulair and it had not been ordered from the pharmacy on admission.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>						

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F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on record review and interview, the facility failed to ensure a newly admitted resident received their ordered medications from the pharmacy in a timely manner, failed to ensure that only medications provided and prescribed for the resident were utilized and failed to ensure they followed the facility policy for medication errors for 1 of 3 residents reviewed for medications. (Resident B)</p> <p>Findings include:</p> <p>A current facility policy, dated 1/1/04, and titled "Special Deliveries" and</p>			F0425	<p>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - No corrective action can be made at this time for Resident B, because this resident was discharged prior to the commencement of this survey. - Nurses involved in the medication errors detailed in this alleged deficiency have been educated or disciplined per policy. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - All newly admitted residents have the</p>		09/01/2012

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	<p>provided by the Director of Nursing (DON) on 8/1/12 at 12:45 P.M., indicated,</p> <p>"Policy: New medication orders received by the facility and deemed necessary for administration before the next scheduled pharmacy delivery due to the urgent nature of the drug or the diagnosis of the resident can be received through a special delivery procedure.</p> <p>Procedure: ... 3. ... When a delivery is designated as a "STAT" as determined by the circumstance and confirmed by the pharmacist, it will arrive at the nursing facility with a four-hour window."</p> <p>A current undated facility policy titled "Nursing Admission Checklist" and provided by the Administrator on 8/1/12 at 10:25 A.M., indicated the nursing staff must,</p> <p>"... verify admission orders with the MD."</p> <p>A current undated facility policy titled "Medication and Treatment incidents and drug reactions" and provided by the Director of Nursing (DON) on 7/31/12 at 1:20 P.M., indicated,</p> <p>"Purpose: To safeguard the resident. To identify causes and prevent future errors</p> <p>...</p> <p>Procedure: ... 2. An entry of the incident will be made in the clinical record ...</p>		<p>potential to be affected by the alleged deficient practice. - The contracted pharmacy has confirmed their ability to provide medications 24 hours every day, and has a contract with another nationwide pharmacy to provide backup medications as needed. The contracted pharmacy will deliver medications within four hours of receipt of physician's orders. A. If unpreventable events hinder deliver of medications administration per physicians' orders, the Emergency Drug Kit (EDK) will be utilized in accordance to regulation. Otherwise, the physician will be contacted to request an order to hold, to delay, or to use an alternative course of treatment. B. All licensed nurses and QMAs will be re-educated as to the medication administration policy. C. All licensed nurses and QMAs will be re-educated as to the facility policy for medication errors. - What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - A. All licensed nurses will be re-educated as to the process for obtaining medications or alternate direction as prescribed by the physician, as outlined above. As part of job-specific orientation, newly hired nurses will be educated as to the process for obtaining medications or alternate direction as prescribed by the</p>				

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	<p>1.a. The record for Resident 'B' was reviewed on 7/31/12 at 12:15 P.M.</p> <p>Diagnoses for Resident 'B' included but were not limited to chronic obstructive pulmonary disease, asthma, shortness of breath, depression, coronary artery disease, osteopenia, gastroesophageal reflux disease and hypothyroidism.</p> <p>Resident 'B' was admitted to the facility on 5/15/12 at 18:38:42 (6:38 P.M.).</p> <p>The physician's orders on admission included, but were not limited to the following medications: albuterol-ipratropium nebulizer inhalation every 4 hours, next dose due at 8:30 p.m. fluticasone-salmeterol (advair) 500-50 inhalation, twice a day, next dose due at 9:00 p.m. montelukast (Singulair 10 milligrams [mg]) orally every evening, next dose due at 9:00 p.m. rosuvastatin (Crestor 5 mg orally) once a day, next dose due at 9:00 p.m. trazadone (150 mg orally) at bed time, next dose due at 9:00 p.m. verapamil (40 mg orally) twice a day, next dose due at 9:00 p.m.</p> <p>Review of "Special Delivery Request" for medications was faxed "STAT" to the pharmacy from the facility on 5/15/12 at</p>				<p>physician, as outlined above. Licensed nurses or QMAs identified as failing to follow these policies will be re-educated and/or disciplined in accordance with facility policy. - B. All licensed nurses and QMAs will be re-educated as to the medication administration policy. As part of job-specific orientation, newly hired nurses and QMAs will be educated as to the medication administration policy. Licensed nurses or QMAs identified as failing to follow these policies will be re-educated and/or disciplined in accordance with facility policy. - C. All licensed nurses and QMAs will be re-educated as to the facility policy for medication errors. As part of job-specific orientation, newly hired nurses and QMAs will be educated as to the facility policy for medication errors. Licensed nurses or QMAs identified as failing to follow these policies will be re-educated and/or disciplined in accordance with facility policy. - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: - For two months, nursing management will audit each new admission for the timely delivery of medications, administration of medications per physician's orders, and utilization of the EDK. Any medication errors identified will be audited for</p>		

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	<p>(20:16:46) 8:16 P.M.</p> <p>Review of the delivery log from the pharmacy indicated the medications were not delivered within the four hour time frame. The facility did not receive the medications until 5/16/12 at 2:44 A.M..</p> <p>b. Review of the resident's MAR for May indicated the resident had an order for Trazadone 150 mg orally at bed time. The record lacked documentation of the resident receiving the medication on 5/15/12 but received the medication on 5/16/12 at 9 and 12 A.M., and on 5/17/12 at 9 and 8 (no A.M. or P.M. designated for the other medication times).</p> <p>Review of a document titled "Medication Dispensing Events" and provided by the DON on 8/1/12 at 10:45 A.M., indicated LPN # 4 attempted to give Resident 'B' Lorazepam without a physician's order. Additional information provided on the record indicated the nurse was using the wrong MAR and the resident refused to take the medication.</p> <p>Review of the admission orders indicated the record lacked documentation of a physician's order for Lorazepam. Review of the clinical record lacked documentation of the medication error according to the facility policy.</p>				<p>adherence to the medication policy and tracked on a medication error log. - Information gathered from the audits will be forwarded to the Quality Assurance Committee to determine a future auditing schedule.</p>		

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	<p>c. Review of the MAR for May indicated the resident had received her Albuterol nebulizer treatment on 5/16/12 at 12 A.M. even though the medications were not received from pharmacy until 5/16/12 at 2:44 A.M.</p> <p>During an interview with LPN #1 on 7/31/12 at 3:00 P.M., she indicated "there were problems with the pharmacy, they didn't have a medication and needed clarification of the physician's orders. It was late, there was a lot of havoc going on and the physician had not called us back. We had to make several phone calls and the Administrator finally had to call the physician directly. The resident was very upset about her medications."</p> <p>During an interview with the 1st floor Unit Manager (UM) on 8/1/12 at 3:20 P.M., she indicated she had called LPN #1 and LPN #2 and the nurses had told her LPN #2 had charted the Trazadone administered on 5/16/12 at 12:00 A.M., instead of on 5/15/12 at 12:00 A.M. and when LPN #1 came on shift she just charted above the previous nurses initials. The UM could not explain how LPN #2 could have given the Trazadone at 12:00 A.M., when the medications were not delivered until 5/16/12 at 2:44 A.M.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/02/2012	
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	<p>On 5/17/12, LPN #1 charted administering Trazadone at 9 and LPN #3 charted Trazadone administered on 5/17/12 at 8.</p> <p>During the same interview the UM also indicated LPN #2 had indicated the resident's albuterol nebulizer treatment was administered to her prior to the medication delivery time because she had used someone else's medications by mistake.</p> <p>3.1-25(a)</p>						

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure complete and accurate documentation of the medication administration record (MAR) for 1 of 3 residents reviewed for medication administration. (Resident 'B').</p> <p>Findings include:</p> <p>The record for Resident 'B' was reviewed on 7/31/12 at 12:15 P.M.</p> <p>Diagnoses for Resident 'B' included but were not limited to chronic obstructive pulmonary disease, asthma, shortness of breath, depression, coronary artery disease, osteopenia, gastroesophageal reflux disease and hypothyroidism.</p> <p>Resident 'B' was admitted to the facility on 5/15/12.</p>			F0514	<p>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>- No corrective action can be made at this time for Resident B, because this resident was discharged prior to the commencement of this survey.</p> <p>- Nurses involved in the medication errors detailed in this alleged deficiency have been educated or disciplined per policy.</p> <p>- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>- All newly admitted residents have the potential to be affected by the alleged deficient practice. All licensed nurses and QMAs will be re-educated as to required</p>		09/01/2012

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	<p>The resident had physician's order for Trazadone 150 milligrams by mouth at bedtime and Albuterol Ipratropium 2.5 mg nebulizer every 4 hours.</p> <p>The May MAR for Resident 'B' indicated the resident was given the medications on 5/16/12 at 9 by LPN #1 and on 5/16/12 at 12 A.M. by LPN #2 and on 5/17/12 at 9 by LPN #1 and at 8 by LPN #3. The May MAR for the Albuterol nebulizer, dated 5/15/12 for 8 P.M., was blank and the resident received the nebulizer treatment on 5/16/12 at 12 A.M.</p> <p>During an interview with the 1st floor Unit Manager (UM) on 8/1/12 at 3:20 P.M., she called LPN #1 and LPN #2 and she indicated the nurses had told her LPN #2 had charted the Trazadone administered on 5/16/12 at 12:00 A.M., instead of on 5/15/12 at 12:00 A.M. and when LPN #1 came on shift she just charted above the previous nurses initials. The UM could not explain how LPN #2 could have given the Trazadone at 12:00 A.M., when the medications were not delivered until 5/16/12 at 2:44 A.M. On 5/17/12 LPN #1 charted administering Trazadone at 9 and LPN #3 charted Trazadone administered on 5/17/12 at 8.</p> <p>3.1-50(a)(1)</p>				<p>documentation on the medication administration record per the medication administration policy.</p> <p>- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>- All licensed nurses and QMAs will be re-educated as to required documentation on the medication administration record per the medication administration policy. As part of job-specific orientation, newly hired nurses and QMAs will be educated as to required documentation on the medication administration record per the medication administration policy. Licensed nurses or QMAs identified as failing to follow these policies will be re-educated and/or disciplined in accordance with facility policy.</p> <p>- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>- For two months, nursing management will perform five random observations per week of licensed nurses and QMAs for proper medication administration and documentation per the medication administration policy. Thereafter, five random observations per month of licensed nurses and QMAs for</p>		

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				<p>proper medication administration and documentation per the medication administration policy.</p> <ul style="list-style-type: none"> - Any medication errors identified will be audited for adherence to the medication error policy and tracked on a medication error log. - Information gathered from the audits will be forwarded to the Quality Assurance Committee to determine a future auditing schedule. 			